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KANSAS HEALTH POLICY AUTHORITY

2009 Medicaid Transformation Program Review
Professional Services

Description

The Centers for Medicare and Medicaid Services (CMS) requires Medicaid programs to reimburse for professional services on behalf of their beneficiaries. This report will focus on three provider types: physicians, advanced registered nurse practitioners (ARNPs), and physician assistants (PAs) and the professional services they provide. Services are delivered in a variety of settings and include preventive care, well child services, and treatment for illnesses, chronic diseases, and traumatic injuries. This report targets cited professionals delivering services to Medicaid beneficiaries through Fee for Service Programs (FFS). All three provider types are able to bill Evaluation and Management Codes, or E&M codes, write prescriptions, and must enroll and bill independently. Mid-level practitioners, however, provide a more limited range of services when compared to physicians and are subject to a reduced payment, receiving 75 percent of maximum rates.

All three provider types practice under the guidance of the Code of Federal Regulations. Physicians are guided by §42CFR, 424.11, Advanced Practice Nurses are guided by 42CFR, 410.75, and Physician Assistants practice under 42CFR, 410.74. Each discipline is also governed by a state licensing and regulatory board. Physicians are subject to the Kansas Physician Practice Act and a variety of statutes, rules or regulations under the Kansas Healing Arts Act, nurses serve under the Kansas Nurse Practice Act, and physician assistants serve under the Physician Assistants Licensure Act and a variety of statutes, rules and regulations under the Kansas Healing Arts Act.

Table 1 identifies the number of physicians, ARNPs, and PAs participating in Medicaid.

Table 1: Provider Participation in Medicaid

	2005	2006	2007	2008	Participation Rate in Medicaid
Physicians					
Kansas Board of Healing Arts	NA	NA	NA	7,609*	
Kaiser State Health Facts	NA	NA	NA	7,816	
Kansas Medicaid Provider Enrollment *(maintained by Electronic Data Systems-EDS now a division of Hewlett Packard)*	11,788	11,987	12,017	12,536	
Kansas Medicaid - By DSS report *(see below for DSS definition)*	6,742	6,833	6,695	6,776*	89%
Physician Assistants					
Kansas Board of Healing Arts	NA	NA	NA	722*	
Kaiser State Health Facts	NA	NA	605	796	

	Kansas Medicaid Provider Enrollment *(maintained by Electronic Data Systems-EDS)*	590	554	602	665	
	Kansas Medicaid - By DSS report	376	420	434	445*	61%
Advanced Practice Nurses						
	Kansas State Board of Nursing	2,734	2,869	3,031	3,159*	
	Kaiser State Health Facts	NA	NA	NA	NA	
	Kansas Medicaid Provider Enrollment *(maintained by Electronic Data Systems-EDS)*	2,073	2,219	2,355	2,594	
1.	Kansas Medicaid - By DSS report	1,239	1,354	1,387	1,542*	49%
DSS is a decision support system designed to facilitate the use of Medicaid data.						

The total number of providers differs depending on the source of the information with variance between sources attributed to the manner in which providers are counted when claims data is analyzed. The Kansas Medicaid Provider Enrollment Unit counts each practice location for any provider independently thus providers who practice in several different locations are counted more than once, yielding duplicated counts. The Kansas Medicaid DSS participation rates were calculated using the number of active, licensed, nonfederal professionals derived from statistics maintained by the State Licensing Boards. That number is divided into the number of providers in the DSS claims count. This method is more reflective of the actual number of Medicaid providers since providers who have not billed in the past eighteen months are excluded. Based on the DSS methodology, 89 percent of physicians licensed in Kansas are enrolled as Medicaid providers. Physician Assistants have an overall participation rate of 61 percent and Advanced Practice Nurses have a 49 percent participation rate.

Any provider failing to submit claims in an 18-month period is subject to disenrollment from the Kansas Medicaid Provider Enrollment Unit. In 2006, 18 providers (all types) were disenrolled, in 2007, 1760 providers (all types) were disenrolled, and in 2008, 98 providers (all types) were disenrolled. In 2007, the National Provider Identifier (NPI) policy was implemented which contributed to the high number of disenrollments, due to elimination of duplicate provider entries.

Despite anecdotal observations of a low physician participation rate in Medicaid, data indicates that a large percentage of the physicians licensed in Kansas enroll in Medicaid. However, some limit their panel of Medicaid patients, making it difficult for beneficiaries to find a provider in some counties even when it appears that the program has an adequate number of physicians enrolled. It is unclear why the enrollment rates for advanced practice nurses and physician assistants are lower than that of physicians.

KHPA encourages input from providers who participate in Medicaid and offers formalized opportunities to be involved in program activities:

- Drug Utilization Review Board (DUR) -This committee membership includes pharmacists and professional providers who meet quarterly to recommend approval criteria for drugs requiring prior authorization (PA).There are two categories of drugs that require PA; those that are non-preferred on the preferred drug list (PDL) and those that require restrictions on their use due to risk factors, inappropriate prescribing, over-utilization, or cost.

- Preferred Drug List (PDL) - The PDL Committee reviews specified therapeutic classes of drugs to determine clinical equivalency. They make recommendations after examining

evidence-based systematic drug class reviews done by the Center for Evidence-Based Policy and the Agency for Healthcare Research and Quality (AHRQ).

- Professional Education and Peer Review Committee (PERC) - The PERC is a board charged with advising KHPA on clinical and quality of care issues affecting the HealthConnect (HCK) and Fee for Service (FFS) beneficiaries.

- Medical Care Advisory Committee (MCAC) - This is a group mandated by 42CFR 431.12(d) (1), (2), and (3). The function of this group is to review and advise using evidence cited in medical literature, examining aggregated population data on medical services and appropriateness of coverage in KHPA Public Insurance Programs. The MCAC also develops recommendations regarding data collection for program evaluation and the development of quality initiatives.

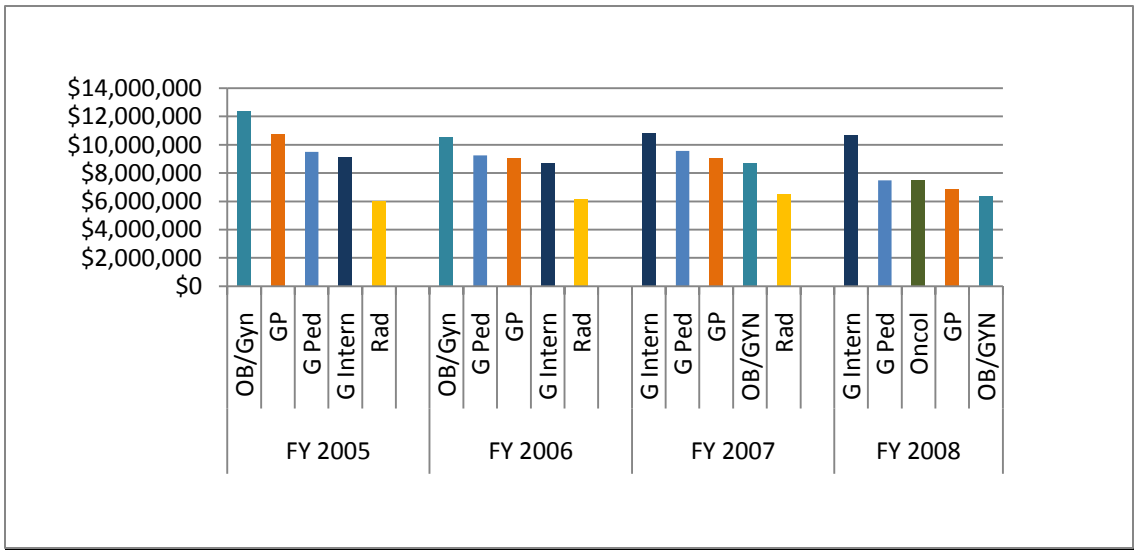
- Provider Task Force- This is a group of either providers or staff representatives who meet semi-annually to discuss provider concerns. The KHPA fiscal agent also attends these meetings on topics ranging from billing and reimbursement issues to discussions about new policies.

- Mental Health Prescription Drug Advisory Committee- This committee was created in 2009 to recommend to KHPA strategies for appropriate management of medications used to treat mental illness. Members include several psychiatrists, social workers, and pharmacists specializing in mental health, consumers, primary care physicians, and others.

Service Utilization and Expenditures

Figure 1 displays the highest physician expenditures by specialty for Fiscal Years 2005 – 2008 in Kansas' Medicaid's FFS program.

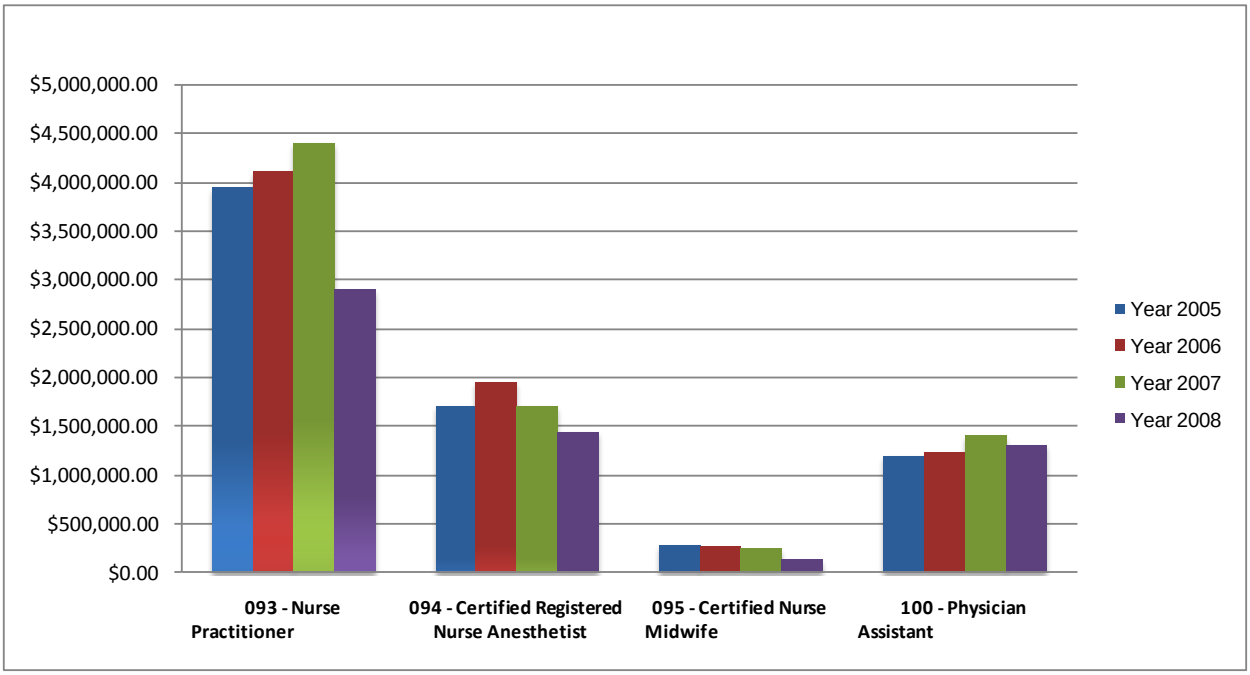
Figure 1: Highest Physician Expenditures by Specialty FY 2005 - 2008



The reimbursement to the provider specialty Ob/Gyn has decreased steadily since 2005 which corresponds with the transfer of pregnant women to the Managed Care Program over the past several years. In 2007 the highest physician category expenditure was for general internists and in 2008 the oncologist specialty category was added to the highest physician expenditures group, reflecting a fee-for-service beneficiary population with an aged and disabled concentration.

Figure 2 depicts expenditures for various types of mid-level providers for Fiscal Years 2005 – 2008. ARNPs are licensed in three categories: nurse practitioner (NP), certified registered nurse anesthetist (CRNA), and certified nurse midwife (CNM).

Figure 2: Expenditures by Provider Type FY 2005 - 2008



The highest expenditure to mid-level providers was for services provided by nurse practitioners, which reached nearly $4.5 million in 2007. Reimbursement to all mid-level providers totaled $7.1million in 2005, $7.5 million in 2006, $7.7million in 2007, and $5.7million in 2008. Reimbursement to mid-level providers was less than one percent of reimbursement to physicians during the same time period.

All Medicaid beneficiaries start out in the FFS program regardless of which benefit plan they will ultimately be assigned. For example, over half of all Medicaid beneficiaries receive care through the HealthWave program. However, beneficiaries have a forty-five day window in which to choose their plan. During these forty-five days beneficiaries are placed in FFS and may receive medical services through the FFS program. Table 2 below shows the number of unique beneficiaries who received services through the FFS program for each fiscal year. The number of consumers served through FFS is greater than the actual number of beneficiaries in the FFS program because of the overlap with other benefit plans such as MediKan, Qualified Medicare Beneficiaries, Low-Income Medicare Beneficiaries, HealthWave and others.

Table 2: Medicaid Beneficiary Claims

Kansas Medicaid Consumer Information					
SFY	No. of Unique Consumers	% change from previous year	No. of Claims per Consumer	Net Paid per Claim	Net Paid Per Consumer
2005	221,035	N/A	11	$40	$428
2006	224,673	2%	8	50	413
2007	200,296	-11%	8	61	493
2008	195,927	-2%	8	57	447

Table 2 provides data on Kansas Medicaid consumer utilization for Fiscal Years 2005 - 2008. The number of beneficiaries receiving services has decreased since 2005. In 2005 there were 221,035 unduplicated beneficiaries seen by Medicaid providers but by the end of 2008, there were only 195,927 unique beneficiaries, an overall decrease of 11 percent. The decrease is due in part to new citizen documentation requirements which have resulted in fewer individuals and families applying for and meeting all necessary enrollment requirements and the transfer of well children and pregnant women to the Managed Care Program. The counts above provide an indication of trends since 2005, but another reflection of the overall size of the FFS program comes from subtracting the number of beneficiaries enrolled in managed care for their physical health services from the total number of Medicaid and CHIP enrollees. By that method, Kansas Medicaid's FFS program was the primary health plan for approximately 136,000 Medicaid beneficiaries at the end of SFY 2008, compared to 159,000 HealthWave enrollees.

Table 3: Expenditures by Beneficiary Category FY 2005 - 2008

	2005	2006	2007	2008
Population Group	**Net Paid**	**Net Paid**	**Net Paid**	**Net Paid**
Aged	$4,253,158	$3,959,494	$6,047,621	$5,658,682
Disabled	33,468,018	35,760,560	44,422,739	48,268,908
Families	45,352,627	41,437,202	35,251,392	20,701,664
General Assistance	5,229,964	5,381,813	5,770,644	4,225,140
Other	6,255,476	6,217,324	7,265,252	8,609,481
SCHIP	629	-3,082	35,311	40,029
Totals	**$94,559,873**	**$92,753,310**	**$98,792,959**	**$87,503,906**

Total expenditures for aged beneficiaries increased 53 percent in 2007 due to a 4.2 percent growth in volume of beneficiaries and provider rate increase following implementation of the provider assessment.

Figure 3: Reimbursement for Top 5 Diagnoses

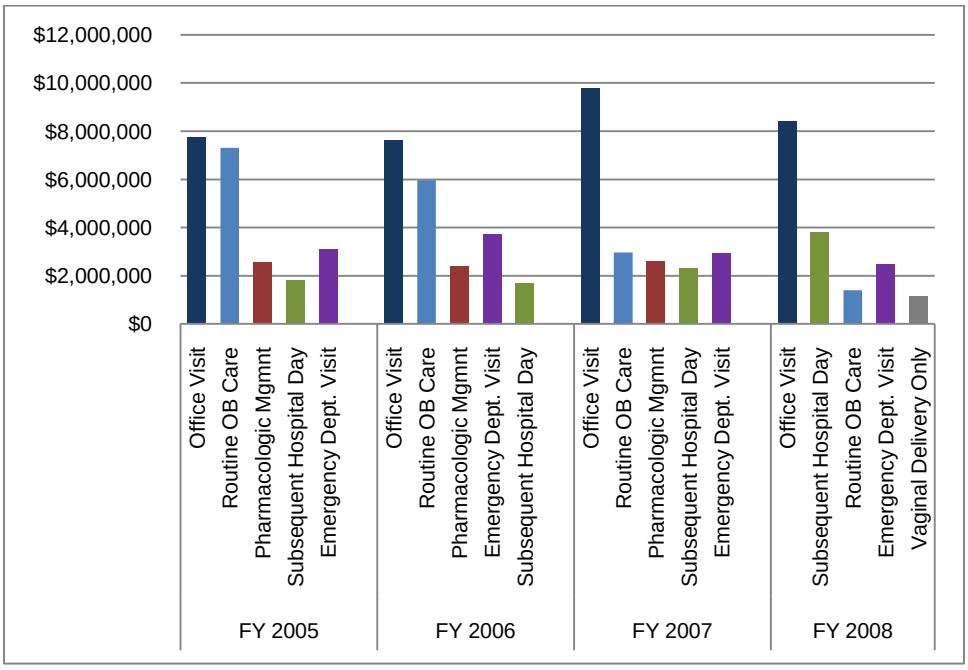


Figure 3 displays the highest expenditure categories for professional services provided in the FFS health plan. For all Fiscal Years 2005 – 2008 the greatest expenditure service category was office visits. In FY 2005 – 2007, routine obstetrical care, delivery, and post-partum care are the second highest expenditure service category. Professional services provided during a visit to the emergency room were consistently in the highest expenditure category of services, and did not decline when more than 40,000 beneficiaries were transferred into the HealthWave program in January 2007.

Figure 4: Highest Expenditures by Diagnosis Category FY 2005 – 2008

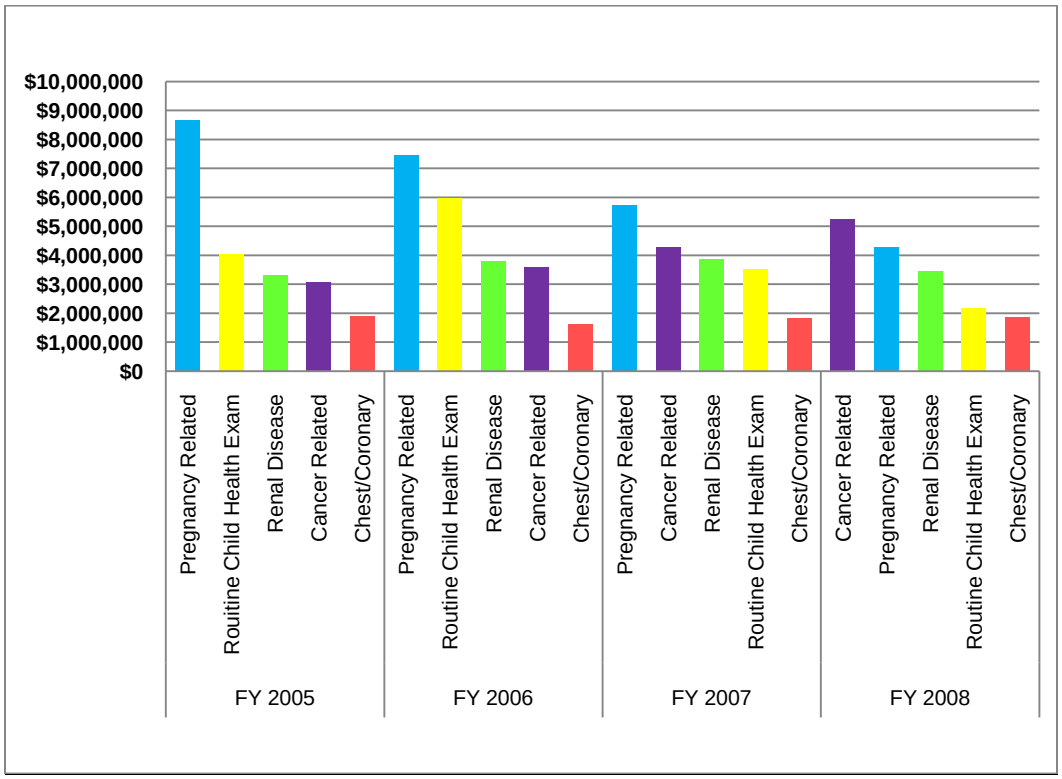


Figure 4 depicts the highest expenditure diagnosis code categories. During FY 2005 – 2008 pregnancy related and routine child health exam services were among the highest expenditure diagnosis categories. In 2008 cancer related became the highest diagnosis expenditure category, due both to the transfer of children and pregnant women to the HealthWave Managed Care Program, and to a steady increase in spending for cancer. Between 2005 and 2008, spending on cancer rose by about $2 million, or about 66%. Some of this increase is due to the provider rate enhancements implemented in 2007, but we expect that this explains only a portion.

Program Evaluation

State and National Workforce Trends

Currently, there are approximately 991,066 physicians nationwide. There are 147,295 Advanced Registered Nurse Practitioners and 73,893 Physician Assistants in the United States (Kaiser Family Foundation, 2008). Due to a variety of factors such as the aging of the workforce, physician attrition rates, and problems training and recruiting an adequate number of nurses and mid-level practitioners, it is possible that we will be facing shortages in certain specialties and in underserved areas. If these shortages occur, they will likely affect Kansas, especially as they relate to providing care to the Medicaid population.

There is no standard rate of attrition defined in the health care industry for physicians, and age of retirement varies for U.S. physicians (U.S. Department of Health and Human Services Administration). Physician attrition rates are an important indicator of the future physician

workforce needs, but attrition among physicians is difficult to measure as they tend to remain licensed beyond the time they practice. According to "No Exit: An Evaluation of Measures of Physician Attrition" (Rittenhouse, 2004) there have been two state studies by medical societies (California Medical Association 2001 study, "And Then There Were None" and Massachusetts Medical Society, 2002) indicating that physicians were leaving practice in record numbers due to frustration and dissatisfaction. The article states; however, that the primary reason physicians actually left practice was due to advancing age. This study was limited in that it, reviewed only urban physicians and physicians primarily practicing in California, so it may not be reflective of all areas of the country.

According to a study by the U.S. Department of Health and Human Services Administration, in the years 2000 to 2005, the percentage of female medical graduates has risen from 10 to 50 percent. This trend may lead to workforce shortages since female physician tend to spend fewer hours per year providing patient care and retire earlier. The higher percentage of female physicians may also lead to shortages in specific specialties and in certain regions of the country or states since women are also less likely to select surgical specialties or work in rural areas.

Merritt Hawkins (Merritt Hawkins, 2007) surveyed 10,000 U.S. physicians, aged 50 to 65. Over half (52 percent) of the physicians responding to the survey agreed with the statement that in the last five years, the practice of medicine is less satisfying. Sources of frustration were listed in descending order: reimbursement issues; malpractice issues; long hours; and the pressure of running a business. Almost half (49 percent) of respondents indicated they were planning on making a change of some sort in the next 1-3 years. Among those respondents, 14 percent stated they would retire,12 percent planned to work 20 hours or less a week, 8 percent plan to close their practice to new patients, 7 percent stated they planned to work in a non-clinical setting, and 3 percent planned to work in a non-medical setting. If those predictions are accurate, the impact of physicians leaving the workforce will be significant-- nearly 60,000 physicians would be removed from the clinical workforce. A reduced physician workforce has a direct impact on access to care by Medicaid beneficiaries.

The state of Kansas has developed several strategies aimed at alleviating the potential physician shortage. The Kansas Bridging Program is offered to students in family medicine, general internal medicine, general pediatrics, or medicine/pediatrics residency programs in Kansas. This program began in 1991 with the goal of encouraging medical residents to practice in a rural community upon completion of their residency training. In 2004, there were 63 vacancies at 22 separate organizations. In 2008, there were 200 vacancies at 75 rural healthcare organizations, and this shortage continues to grow. Since 2005, the Bridging Program has placed 68 residents in various rural communities across the state. In this program a community is designated rural if it is not located in Douglas, Johnson, Sedgwick, Shawnee, or Wyandotte County. Resident physicians who participate in the Kansas Bridging Program agree to practice medicine full-time in the selected rural community for 36 continuous months upon completion of their residency training program in exchange for loan forgiveness.

The Health Workforce Data Workgroup was convened in November of 2009. This workgroup is a subcommittee of the Kansas Health Data Consortium. The goal of the workgroup is to review current licensure data, identify gaps, and determine how best to obtain the additional data necessary to support statewide workforce planning while minimizing the cost and burden to providers and associations for collecting it. The timeline includes a total of 3 meetings to

develop a plan that can be presented to the KHPA Board and Data Consortium in March 2010.

A national program known as “The State 30 (Conrad) J-1 Visa Waiver Program”, (Kansas Department of Health and Environment, 2009) is for international students completing their residency in the United States. This program assists in the recruitment and retention of foreign physicians to practice in communities that lack adequate access to primary health care. In 2002, nationwide there were 26,588 foreign physicians in the United States in residency or fellowship trainings. Currently, there are approximately 3,200 foreign-born physicians practicing in underserved areas – compared to only 2,000 American physicians practicing in underserved areas. The program allows state public health departments to recommend that international medical graduates currently holding J-1 visa status be granted a waiver of the J-1 visa two-year home country residency requirement in return for practicing medicine full-time for a minimum of three years in an "underserved" community. Each participating state is allowed 30 slots for the Waiver Program. The underserved communities must be in a population group or facility that is defined as a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA) area as described by U.S. Department of Health Resources and Human Services Administration (HRSA) Shortage Designation Branch.

Although these programs address the problem of placing physicians in underserved communities they do not guarantee that those physicians will participate in Medicaid. Kansas Medicaid has had difficulty recruiting physicians to serve beneficiaries in some rural communities.

Physician Assistants are also affected by factors producing potential provider shortages in other healthcare fields. There is little in the way of research to indicate whether or not a physician assistant shortage is imminent, but based on the other health care shortage expectations, it is feasible that there is also a shortage within this area. An upcoming shortage of professional nurses is predicted and this will likely impact availability of ARNPs in the future.

Provider Payment Trends

In Kansas, a provider rate Increase took place in mid-2006. Based on information provided by a study entitled *Trends in Medicaid Spending* (Zuckerman, Williams, & Stockly, 2009), 25 states increased reimbursement rates between 2003 and 2008. This study updated a similar study from 1998-2003 and used data on Medicaid physician fees along with Medicare fees to examine recent trends in Medicaid physician reimbursement. This survey reviewed fees paid for primary care, obstetrical care, and other services. All states except Tennessee and the District of Columbia had a FFS component in their Medicaid programs. The authors examined whether physician fees were adjusted for specific providers or services to meet policy objectives. Kansas was in the group of 17 states that reported adjusted rates for specific preventive or obstetric services for providers.

The study results indicated that average physician fees for Medicaid ranged from 58 percent of the national Medicaid average in New Jersey to 205 percent in Alaska. Ten states had overall average Medicaid fees that were more than 10 percent below the national average (Kansas was not one of these states). The states with the most consistent pattern of low Medicaid physician fees were Rhode Island and New Jersey, with average fees more than 30 percent below the national average. Overall, between 2003 and 2008, Medicaid physician fees for the surveyed services increased 15.1percent or at an annual rate of increase of 2.6 percent. During that time frame, the Consumer Price index (CPI) increased 20.3 percent or an annual rate of increase of 3.4 percent. The Medical Care Services component of the CPI, which includes physician rates,

grew 28.1 percent or on average annual rate of 4.6 percent, indicating that in real terms Medicaid physician fees declined one percent annually relative to general inflation and about two percent annually relative to the CPI. Kansas was one of five states that increased their average Medicaid fees by twice the rate of inflation during the study period. The study concluded that the current Medicaid to Medicare ratio is approximately 73 percent and that overall, states have not improved payment rates for Medicaid patients relative to Medicare. Other studies indicate that physicians are less likely to accept new Medicaid patients compared to other insured patients.

A separate policy report conducted by the Alliance for Children and Families and the United Neighborhood Centers Association, (Farley, 2009), outlines the history of Medicaid and Medicare payment reforms and discussed the formation of the Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid faces a unique set of issues as rate-setting authority is vested in the states and the fee schedules created by each state may have no relationship to what physicians actually charge for their services. The American Academy of Pediatrics reports that Medicaid reimbursement averages 69 percent of Medicare reimbursement and even a smaller percentage of private reimbursement. Many pediatricians state that they are reluctant to take new Medicaid patients because of the financial strain it places on their practices. As a result, low-income children frequently cannot access the health care services they need and are eligible for under Medicaid. As part of the Children's Health Insurance Program Reauthorization Act of 2009, Congress created a new organization to analyze the access issues facing children in the Medicaid and CHIP programs: the MACPAC. Public Law 111-3, enacted on February 4th, 2009, created the MACPAC and determined the duties of the Commission:

1. Review Medicaid policies that affect children's access to covered health services and make recommendations to Congress regarding these policies.
2. Submit two annual reports to Congress: one containing the Commission's recommendations on access, and the other containing a study of other issues in the health care marketplace affecting the Medicaid and CHIP programs.
3. Include a review of payment policies under the programs and the relationship of these policies to access and quality of care for Medicaid and CHIP enrollees.
4. Institute an early-warning system to inform Congress of pending shortages in the health care workforce and identify provider shortage areas.
5. Review reports submitted to Congress by the Department of Health and Human Services that relate to Medicaid and access issues.

By specifically charging MACPAC with studying the relationship between physician payment and patient access, Congress has recognized that Medicaid enrollees often lack access to important health services for which they are eligible. The creation of MACPAC does not constitute a federal requirement that states raise their reimbursement levels, but it provides a source of unbiased, expert information for Congress to use in debating federal Medicaid policy. Advocates for improved reimbursement rates anticipate that Congress will use the information to make improvements in payment rates and children's access to health care.

Rates for professional services in Kansas have not been systematically reviewed to standardize the rate setting practice. Historically, rates were determined service-by-service based on inquiries from providers or legislators, to re-evaluate prior reduction activities, or following federal mandates. As of 2009 in Kansas, professional services that correspond with Medicare's Physician Fee Schedule are reimbursed at an average of 83% of Medicare rates, with a range from 10% to 800% on individual services. Hospital and outpatient services are reimbursed at 84% of Medicare. Only a portion of professional services were increased in mid-2006 using

funds from a hospital assessment. This 2006 rate adjustment increased rates to 86% of Medicare's higher Non-Facility Physician Fee Schedule, but now is set at 83% of the higher fee schedule due to subsequent increases in Medicare payments.

The Medicare Physician Fee Schedule includes both a facility and a non-facility fee on many services that are performed by professionals. The facility fee is meant for professionals practicing in a hospital rather than their own independent practice. The facility fee is typically lower because the physician only receives reimbursement for professional services; the hospital receives a separate reimbursement for the expenses for the overhead, staff, equipment, and supplies. The higher non-facility fee compensates the physician for those additional practice expenditures when the service is performed in an office setting, in addition to professional services.

As if January 2010, a proposal has been implemented that levels the rate for all professional services that correspond with Medicare's Physician Fee Schedule, to 83% of Medicare's higher Non-Facility Fee Schedule, without regard to the place where the service is performed. The rates previously increased in 2006 along with basic primary care services that currently pay above 83% of Medicare's Non-Facility Physician Fee Schedule are protected. Rates currently paying more than 83% of Medicare's higher schedule have been reduced and rates currently paying less than 83% of Medicare's higher schedule are increased. Exceptions to the rate leveling policy include codes and procedures frequently billed by primary care physicians that were above 83% of Medicare. These selected codes were not reduced to 83% of Medicare. The rate leveling policy would make rates for professional services consistent in comparison to Medicare's higher rates. This payment policy applies a uniform standard to services and establishes a more equitable basis for new policy initiatives that may be implemented in the future, such as the payment-related components of a medical home.

The Professional Provider Program faces current and emerging challenges, including concerns about adequacy and standardization of provider rates. Using Medicare as a benchmark provides a mechanism to systematically update provider payment rates. Other changes which result in Kansas Medicaid mirroring Medicare are potentially expensive and would require more extensive changes to the Medicaid Management Information System (MMIS).

Another provider issue is the documentation of Kansas Medicaid providers' specialty. The Kansas Medicaid Provider Enrollment Unit at Hewlett-Packard Enterprise Services maintains a list of Medicaid providers, which sorts physicians by specialty. For physician specialists the criteria could be strengthened by applying the same specialist definition used by the medical professionals. Data retrieved might be more meaningful and a better predictor of where shortages are likely to occur.

For example, the primary care specialties listed are: obstetrician/gynecologist, general practitioner, general pediatrician, general internist, family practitioner, and preventive medicine. General practice is an antiquated term and should be updated. In addition some subspecialties are absent, such as "endocrinology" which is one of the specialties providing diabetic management services. Diabetic management is important because of the high costs associated with the diabetic population. Lack of ability to measure the cost the specialty contributes to diabetic management prevents assessment of the services.

Finally, Kansas Medicaid has struggled to engage practicing providers as we attempt to improve the program for both beneficiaries and providers. Only providers who participate in the managed care (HealthWave) and HealthConnect networks are included in the yearly provider

survey administered by the Kansas Foundation for Medical Care. The only input we receive from providers who participate in our FFS program is through our advisory groups and committees.

Recommendations

1. Provide input to the Health Professions Workforce group (a sub-group of the Kansas Health Data Consortium) as they design a system that will accurately report the number of professional providers. Due to the differences in the reported numbers in professional providers between the licensing boards and Kansas Medicaid-HP Enterprise Services, it is recommended that rather than counting a provider twice when they have two practice locations, it would be more accurate to count the provider once and consider practice locations as a sub-group.

2. Reorganize the provider specialties to ensure that recorded specialties accurately match provider practices. Many specialty types are not listed and some are outdated. At this time, some procedure codes are denied because one or more of the provider specialties that the provider lists does not match the categories in the system design. Updating the specialty list every one or two years would allow benefit plans to match the code coverage more accurately for physicians as well as PAs and ARNPs.

3. Begin a file documenting the rationale given by a provider when they disenroll from Kansas Medicaid. This data could potentially provide valuable information which could be used to recruit and maintain providers or when developing and updating medical policy.

4. Continue research on the recommendation to mirror Medicare payment rates. A policy has been implemented to adjust the rates for additional procedure codes for professional services. This adjustment brings the new rates in line with rates that were adjusted in 2006 as part of the provider assessment. This policy provides for a more equitable and rational payment policy for professional services.

5. Collect HEDIS-like measures that have been identified as appropriate and relevant to assessing care provided to Medicaid beneficiaries. The Data Analytic Interface (DAI) system has built in HEDIS-like measures that can provide information on preventative care, health outcomes and access to care. These DAI measures will be collected for the Medicaid population. Access and quality should be assessed and evaluated. The only access and quality of care reports that are available are studies done by the Kansas Peer Review Organization, related to Managed Care beneficiaries.

6. Implement a medical home pilot. KHPA will obtain stakeholder input to determine which group of beneficiaries to include in the pilot, measurable outcomes, available resources and identification of Medicaid enrolled providers who are interested in participating.

7. Enhance provider surveys to generate better, more comparable, and more frequent feedback from professionals serving the Medicaid and HealthWave programs.

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